STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185252	A. BUILDING _____ B. WING _____	11/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN NURSING HOME	2582 CERULEAN RD. CADIZ, KY 42211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED An annual survey and abbreviated survey (KY #15351) were conducted on 11/03/10 through 11/05/10 to determine the facility's compliance with Federal requirements. This was a Nursing Home Initiative survey. The facility failed to meet minimum requirements for recertification with the highest Scope/Severity of "D". KY #15351 was unsubstantiated with no deficiencies cited.	F 000	**Plan of Correction Disclaimer for Shady Lawn Nursing Home** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because of State and Federal requirement.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure one resident (#1) in the selected sample of 12, received the appropriate incontinent care to prevent a Urinary Tract Infection (UTI). Additionally, indwelling catheters were not anchored according to the facility's protocol for one resident (#1) in the selected sample and one resident (#14), not in the selected sample. Findings include:	F 315	F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 1. Foley catheter care was provided to resident #1 on 11/5. A foley catheter leg anchor was applied to #1 and #14 on 11/5/10. 2. There are no other residents in the facility with foley catheters. 3. All nursing staff was educated by the Education Director and DON related to appropriate technique of foley catheter care and placement of foley catheter tubing leg anchors. Inservice was initiated on 11/5 and completed on 11/18.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Workman	Administrator	12/2/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185252	A. BUILDING _____ B. WING _____	11/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN NURSING HOME	2582 CERULEAN RD. CADIZ, KY 42211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 1 1. A record review revealed Resident #1 was admitted to the facility, on 09/25/09, with diagnoses to include Failure to Thrive, Alzheimer's, Episodic Mood Disorder, Congestive Heart Failure, Obsessive Compulsive Disorder and Reflux. The resident had an indwelling catheter to facilitate healing of a Stage III pressure ulcer on the coccyx and was treated for a UTI on 10/05/10. A review of the significant change Minimum Data Set (MDS), dated 09/30/10, revealed the facility assessed Resident #1 as moderately cognitively impaired, with mental function varying during the day. The resident was incontinent of bowel and bladder, and bedfast most of the time. He/She did not participate in bed mobility and required the assistance of two staff for transfers, using a mechanical lift. A review of the Comprehensive Care Plan, dated 09/20/10 for daily catheter care, referred to Lippincott Manual of Nursing Practice. The care plan, dated 10/10 for actual/potential for infection, included an intervention for catheter care per protocol. The Treatment Administration Record, dated 11/2010, included Perineal/Catheter (Peri/Cath) care every shift. A review of the Nursing Assistant Assignment Worksheet, dated 10/25/10, revealed Resident #1 was to receive catheter care; however, no specific instructions for catheter care was noted. An observation, on 11/05/10 at 10:05 AM, revealed Certified Nurse Aide (CNA) #1 preformed Peri/Cath for Resident #1. She wiped down each groin/leg fold, then rolled the resident to the left side and wiped from front to back using clean areas of the washcloth. After changing	F 315	4. The Education/Training Director, DON,and/or ADON will perform foley catheter care observations to ensure foley catheter care is provided using appropriate technique and that all foley catheters are anchored, as described in the Lippincott Manual of Nursing Practice. This will be done 3 times a week on random shifts for one month, then monthly for 2 months with results forwarded to QA committee monthly for review and futher recommendations. 11/30/2010	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 2	F 315		

washcloths, she then made several strokes from back to front, then discarded the dirty washcloth. She tucked a clean brief under the resident, and positioned the resident onto his/her back. She pulled the front of the brief up between the resident's legs and fastened the tape tabs at each side, without providing catheter care. When questioned as to whether she intended to perform catheter care, CNA #1 responded, "No, I don't do that." The indwelling catheter was not anchored.

A review of the Lippincott Manual of Nursing Practice procedure for providing catheter care revealed that a female resident should be cleaned from the vulva (vagina) down to the anus using a different part of the washcloth each time until clean, then rinse and dry the vulva and perineum thoroughly. The catheter was to be securely taped to the resident's leg.

An interview with CNA #1, on 11/05/10 at 11:00 AM, revealed she had been employed at the facility for a little over one month. She stated her skills check-off had been signed off by CNA staff and she had not been in-serviced at the facility on catheter care.

2. A record review revealed Resident #14 was admitted to the facility, on 07/02/10, with diagnoses to include Tracheostomy, Infective Polyneuritis and Gastrostomy Status. The resident had an indwelling catheter to facilitate healing of a Stage III pressure ulcer. An observation on, 11/05/10 at 11:30 AM, revealed the catheter was not anchored.

An interview, on 11/05/10 at 12:25 PM, with the Education/Training Director, revealed she had reviewed catheter care with CNA #1, but had no

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F 315	Continued From page 3 documentation of any training provided to the CNA. She further stated she expected catheter care to be performed according to the Lippincott's procedure. She also stated the preceptor assigned to new staff usually checked them off for skills. She was not able to provide a skills check-off list and stated it was all staff members' responsibility to ensure the catheters were anchored according to training provided by the facility. An interview with the Director of Nursing, on 11/05/10 at 12:30 PM, revealed she expected staff to perform catheter care based on the Lippincott manual.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility to failed to ensure residents' environment was as free from accident hazards as possible, for two residents, (#6 and #9) in the selected sample of 12. A chair and an over-the-bed table were placed against the side of Resident #6's bed, while the resident occupied the bed. Additionally, a transdermal medication patch was attached to Resident #9's bedrail. Findings include:	F 323	F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 1. Nitro patch was removed from side rail of #9 and furniture removed from bedside #6 on 11/3. 2. On 11/3/10, RN DON conducted an audit of all rooms in center to ensure there were no medication within reach of residents and that there was no objects in rooms that could be safety hazards 3. All licensed nursing staff educated by the Education/training director and DON regarding the requirement to immediatley dispose used medication patches upon removal from resident and educated all non-licensed nursing staff and environmental staff on requirement to notify nurse immediately if they observe any medication within the reach of residents. This inservicing was inititated on 11/3/10 and completed on 11/18/10. All nursing staff and environmental staff were educated by Education/training Director regarding the requirement to keep resident rooms free from obstructions that could present as safety hazards to residents. These inservices were inititaled on 11/3/10 and completed on 11/18/10	

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F 323	Continued From page 4 1. A record review revealed Resident #6 was admitted to the facility, on 10/22/10, with diagnoses to include End Stage Dementia, Congestive Heart Failure, Atrial Fibulation, Cachexia and Carbuncle to Buttocks. Documentation in the nurse's notes, dated 11/01/10, revealed an abrasion to the resident's left brow and a 1.5 centimeter (cm) laceration to the right brow, a result of the resident rolling out of bed. A review of the admission Minimum Data Set (MDS), dated 11/05/10, revealed the facility assessed Resident #6 as moderately cognitively impaired. An initial care plan, dated 10/22/10, included interventions for a Wanderguard due to decreased safety awareness, the bed against the wall, and the resident was to be turned and repositioned every two hours. The Nursing Assistant Assignment Worksheet revealed Resident #6 was incontinent of bowel and bladder, independent with transfers, needed two staff assistance, dependent for activities of daily living (ADLs), and required a low bed with mat at the bedside. An observation, on 11/03/10 at 6:00 AM, revealed Resident #6 was lying in bed. The bed was against the wall and a mat was on the floor on the left side of the bed. A pink arm chair had been placed on top of the mat, with it's back against the bed. The chair was located approximately two thirds of the way from the foot of the bed. Additionally, an over-the-bed table had been placed along the side of the bed toward the head of the bed. One end of the table was touching the chair. The resident had purple discolorations on the right and left sides of his/her	F 323	4. Room rounds will be conducted by Education Training Director, ADON or DON 3x a week on random shifts for 1 month, then monthly x2 months to ensure no medication is present in resident rooms and no safety hazards exist related to furniture placement. Results of rounds will be presented to QA committee monthly for review and further recommendations. 11/30/2010	

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F 323	Continued From page 5 forehead. A laceration with steri-strips was noted to the right side of the forehead and an abrasion to the left side of the forehead. An interview, on 11/03/10 at 7:30 AM, with Certified Nurse Aide (CNA) #6, who worked the 3rd shift, revealed the chair and the over-the-bed table had been placed in that manner when she started her shift at 10:00 PM on 11/02/10. She stated the charge nurse was aware of the placement as she was in and out of the room all night and did not move the furniture or ask that she move it. The CNA stated she assumed that it was placed there for a reason and only moved it when she provided care and then replaced it. She stated she had never noticed the furniture placed like that before. A phone interview, on 11/03/10 at 7:30 AM, with the 3rd shift Charge Nurse, Licensed Practical Nurse (LPN) #1, revealed the chair and the over-the-bed table were placed in that position at the resident's request because he/she liked it that way. "He/She thinks (a relative) is coming and likes to put his/her eye glasses on the table. The chair is for the family and it gives the resident a sense of security." LPN #1 stated, "It's not for us, it's for the resident's security." She further stated that the resident did not request the furniture be placed that way every night and that she didn't know if the resident asked any other staff to do this. A phone interview, on 11/03/10 at 7:30 AM, with the 1st shift House Keeper, revealed she had noticed a chair at the end of the bed at times, but had never seen a chair and the over-the-bed table placed along side the bed.	F 323		

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F 323	Continued From page 6 A phone interview, on 11/03/10 at 1:00 PM with CNA #7, who worked the 3rd shift, revealed she was aware the resident was very anxious at times. An interview, on 11/03/10 at 1:00 PM, with CNA #2, who worked the 1st shift, revealed Resident #6 yelled out frequently for his/her mother, sister and daughter. She reported the resident wanted to go home and frequently tried to get out of bed. She had noticed the furniture against the bed and had also noticed a wheelchair and the over-the-bed table "long ways against the bed," on previous occasions. A phone interview, on 11/03/10 at 1:05 PM, with CNA #8, who worked the 3rd shift, revealed the resident slept "pretty well" at night, but wanted to get up at times. When staff sat the resident up, they remained with her 1:1. She had no knowledge of the resident ever wanting to have furniture moved in the room. An interview, on 11/04/10 at 12:20 PM, with LPN #2, who worked the 2nd shift, revealed she was working 11/01/10 at 4:40 PM, when Resident #6 rolled out of bed. She stated the resident typically started to become anxious around 4:00 PM, repeatedly trying to get out of bed; however, when staff attempted to get her up, she refused. She further stated, "I don't want to put stuff in front of her because I feel it would be more of a danger to her." She also revealed if staff placed the resident in a wheelchair, he/she usually continued to yell out and leaned forward in the wheelchair. She had no knowledge of why a chair and an over-the-bed table were positioned in front of the bed. She stated the resident made only simple requests and she was not aware of the resident	F 323		

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	185252	A. BUILDING _____ B. WING _____	11/05/2010

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F 323	Continued From page 7 requesting the furniture be moved in any particular way. An interview, on 11/04/10 at 2:45 PM, with CNA #9, who worked the 2nd shift, revealed Resident #6 was "restless mostly everyday" and threw his/her legs over the side of the bed and tried to get out of the wheelchair. She stated she recently had to take turns with a nurse watching the resident. An interview, on 11/04/10 at 10:50 AM, with the Director of Nursing (DON), the administrator, and a Cooperate Nurse Consultant, revealed the DON was not aware of the furniture placement at Resident #6's bedside. She stated she did not believe staff were restraining the resident and staff had been trained and were aware of the restraint policy. She said staff had reported to her that the chair placed at the bedside brought the resident comfort. She believed the resident rested well at night and did not attempt to get up. She stated placing the furniture at the bedside was definitely not a good idea in terms of safety, "but not so much if it comforts him/her." She further stated if she thought it would comfort the resident, she couldn't say she wouldn't have done the same thing. 2. A record review revealed Resident #9 was admitted to the facility, on 08/16/10, with diagnoses to include, Failure to Thrive, Alzheimer, Diabetes, Hypertension, Dysphagia, and Coronary Artery Disease. A review of the Admission MDS, dated 08/22/10, revealed the resident's cognition was severely impaired. An observation, on 11/03/10 at 9:15 AM, revealed a Transdermal Nitroglycerin 0.4 mg patch was	F 323		

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	185252	A. BUILDING _____ B. WING _____	11/05/2010

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F 323	Continued From page 8 attached to the right bedrail of Resident #9's bed. A review of the physician's orders, dated 08/16/10, revealed an order for Nitroglycerin 0.4 mg/hr patch, applied once daily in the AM and removed in the PM. The Medication Administration Record, dated 08/16/10, revealed the patch was applied at 8:00 AM and removed at 8:00 PM. An interview, on 11/04/10 at 2:00 PM, with LPN #2, revealed she had removed the Nitroglycerin transdermal patch from Resident #9 at 8:00 PM on 11/02/10. She laid it at the foot of the bed. She stated she then flushed the feeding tube and meant to pick up the patch before leaving the room but forgot it. She stated she realized it was a safety hazard and it was her responsibility to dispose of it properly. An interview with the DON, the administrator and a Corporate Nurse Consultant, on 11/04/10 at 10:50 AM, revealed the DON completed an investigation of the Transdermal patch observed on the bedrail of Resident #9's bed. She also revealed an in-service had been conducted, which included instructions for medication patches to be flushed, or put in the sharps container and that all staff was responsible for maintaining a safe environment. She stated that if other individuals had come in contact with the patch, it could have caused their hearts to race or they could have become dizzy.	F 323		

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	185252	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/03/2010

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 11/03/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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